2004 Annual Report

ESRD Network Area #3

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Submitted to:

Kathleen Egan, Project Officer
Division of HSQ/CMS
Room 2325
JFK Federal Building
Government Center
Boston, MA 02203

Submitted by:

Trans-Atlantic Renal Council
Cranbury Gates Office Park
109 South Main Street
Suite 21
Cranbury, NJ 08512-3142

June 30, 2005

1. Preface

On behalf of all chronic renal care facilities within Network 3, I am pleased to submit this 2004 annual report of performance and achievements.

All facility staff are to be commended for their efforts to meet goals and participate in the various projects and activities of the network. The National Vascular Access Improvement Initiative has shown success in increasing the number of fistulas in use by hemodialysis patients although continued attention to this project will result in even higher rates of use. Significant effort has been made to include surgeons in the vascular access project and this will continue so that consumers can benefit from a well-functioning fistula. Such sustained progress serves as a testament to the dedication and commitment of professional staff. The project will see a more focused effort to educate consumers about the benefits of fistula use.

All recognize the difficulties inherent in reducing the number of long-term catheter access and those who have developed a team approach to this effort continue to see improvement. Technical assistance will continue to be provided to further reduce these rates.

I want to acknowledge the contribution of all the voluntary board and committee members who worked so assiduously in the development of network activities and the oversight of improvement efforts. Such service is appreciated and brings satisfaction in reviewing results that impact the lives and medical status of renal consumers of care.

Finally I would like to express our appreciation to network staff that coordinate and support all the administrative work we perform.

We look forward to the continuation of this partnership with the Centers for Medicare & Medicaid Services, facility staff, consumers, departments of health and other interested agencies as we begin another phase of health care quality improvement projects.

Jorge Weber, MD
President, Board of Trustees

June 30, 2005

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2. Introduction

A. Network Description

New Jersey contains 8,215$^{\nabla}$ square miles with 21 counties and 567 municipalities. Its highest elevation is 1,803 feet at High Point and its lowest is sea level at the Atlantic Ocean with an average elevation of 250 feet. Although New Jersey is geographically one of the smallest states in the nation (it ranks 46th), it is the ninth most populous, with approximately 8.6 million residents. There are 1,164.6 inhabitants per square mile of land area - the most densely populated state in the nation.

The majority of residents reside in metropolitan areas with only 10.6% in rural areas. The U.S. Census Bureau categorized only New Jersey and the District of Columbia as 100% metropolitan areas. The only area to surpass New Jersey in degree of urbanization is California (92.6%) where it has the largest resident state population (35.4 million). However, California has a population density of only 227.5/sq. mi.

Approximately 1.1 million (13%) of New Jersey's population base is aged 65 and older. The highest concentration of those age 65 or older is found in Ocean and Cape May counties. Nationally, seventeen other states had a higher percentage of those 65 and older; the national average is 12.4 per cent.

Not all age groups are equally constituted. The under 5 age group constitutes 6.6% of the resident population; the 5-17 age group accounts for 18% of the population; the 18-24 group for 8%, the 25-44 age group for 30%; the 45-54 for 14%, the 55 to 64 group for 9.6% and the 65+ age group for 13% of the population. It is important to note that from 1990 - 1998 the 85 and older age group increased by 38%. This growth in the aged population among the residents of New Jersey contributes to the increase in the mean age of consumers presenting for renal therapy due to end-stage disease.

The population is reported to be 77% white, 14.5% black, 6.5% Asian and 2% other. Most of the population growth in New Jersey during the last decade occurred in minority populations; Hispanics sustained the largest increase. Hispanics now constitute approximately 14.5% of the population within New Jersey and Hispanics of Puerto Rican decent comprise more than 33% of all Hispanic residents. The largest increase of New Jersey’s Hispanic residents occurred in Hudson and Passaic counties.

New Jersey is surpassed by only 6 other states in the proportion of resident Hispanic or Latino residents. California (34.3%), Texas (33.6%), Arizona (27.7%), Florida (18.6%), Illinois (13.6%) and New York (16.3%) surpass New Jersey’s 13.3% resident Hispanics and Latinos.

For the year 2000, New Jersey ranked fifth in the number of immigrants admitted from other countries and was surpassed only by the states of California, Florida, New York and Texas. The US Census Bureau reported the admission to New Jersey of 59,920 immigrants from other countries with 9,154 from India, 3,262 from China, 2,905 from the Philippines, 2,316 from El Salvador, 1,788 from Haiti, 1,361 from Cuba, 1,098 from Mexico, 500 from Vietnam and fewer from other countries. Foreign-born residents account for 17.5% of the state’s population, exceeded only by California (26.2%) and New York with 20.4%.

Eighty-three per cent of New Jersey residents were born in the United States. New Jersey's birth rate of 13.4 is lower than the national rate of 13.9/1,000 estimated population as is its fertility rate (per 1,000 women aged 15-44 years estimated) of 63.5 vs. 64.8. Death rates by cause show the leading cause to be heart disease followed by cancer, cerebrovascular diseases, chronic obstructive pulmonary diseases, diabetes mellitus, accidents, assaults and HIV. The death rate was 8.6 (per 1,000) in 2002 while the national rate was 8.5.

The marriage rate (per 1,000 population) in 2001 was 6.6, higher than the 1998 rate of 5.9, but still lower than the national rate of 8.2; divorce rates were reported to be 3.5 in New Jersey and 3.9 nationally for 2001.[▽]

In 1998, the latest available Census data showed New Jersey per capita personal health care expenditures ($2,900/resident) were exceeded only by the states of Connecticut ($3,298), New York ($3,255), Pennsylvania ($2,941) and Rhode Island ($2,937). The major portion was expended on hospital services followed by physician services, drugs and non-durables, nursing home care, other professional services, dental services, home health care, other personal health care and medical durables.

Health insurance coverage did not extend to 13.9% in 2002 of the New Jersey population; the national average in 2002 was 15.2% and 14.0% in 2000. Children not covered in New Jersey in 2002 was 9.7%, 9.3% in 2000; the national average was 11.6% in 2001 and 11.6% in 2000.

Excluding doctors of osteopathy and federal employees, New Jersey in 2001 had 305 physicians per 100,000 population, a slight increase over the 2000 rate of 298, which in both years was exceeded only by the states of Connecticut, Maryland, Massachusetts, New York, Vermont, and Rhode Island. The 2002 national rate was 256 and in 2001 was 253.

Twenty states surpassed New Jersey with its rate of 856 nurses per 100,000 population (805 in 2000); the national rate was 797.

The percentage of New Jersey residents with advanced educational degrees (8.8%) exceeds the national average of 7.2%. Eight states exceeded the New Jersey rate. In 2000, 87.3% were high school graduates and 30.1% had bachelor's degrees or higher levels of attainment; in 2003 86.2% were high school graduates and 33.4% had bachelor's degrees or higher levels of attainment

In 2003, the average elementary and secondary school teacher's salary in New Jersey was $54,200. New Jersey was surpassed by only three other states for secondary salaries: California, Connecticut and Illinois ($58.0, $56.6 and $56.4). The national average for all elementary and secondary was $43,300 in 2001; in 2003 it was $45.9.

The New Jersey unemployment rate[#] for 2004 was recorded to be 5.9%. Variations among the 21 counties ranged from 3.2% to 6.8%.

New Jersey Unemployment Rate, by County, Selected Years, 1990-2004

COUNTY	1990 (%)	1995 (%)	1999 (%)	2000 (%)	2002 (%)	2003 (%)	2004 (%)
Atlantic	6.2	8.6	7.2	5.7	6.6	6.9	6.1
Bergen	3.9	5.8	3.7	3.1	5.0	4.9	4.0
Burlington	4.6	5.0	3.3	2.9	4.6	4.6	4.2
Camden	5.9	6.4	4.6	3.9	5.8	6.1	5.4
Cape May	7.7	12.1	10.1	8.6	9.6	9.9	6.8
Cumberland	7.5	9.8	8.6	7.2	8.5	8.6	6.7
Essex	6.3	7.7	5.7	4.7	7.3	7.3	5.9
Gloucester	5.6	6.5	4.5	3.8	5.2	5.5	4.9

[▽] All demographic, education, employment data taken from *Statistical Abstract of the United States,* 123rd or 124th Edition, whichever had the most recent data.

[#] Source: NJ Dept of Labor and Workforce Development Web site; www.wnjpin.net/OneStopCareerCenter/LaborMarketInformation

New Jersey Unemployment Rate, by County, Selected Years, 1990-2004							
COUNTY	**1990 (%)**	**1995 (%)**	**1999 (%)**	**2000 (%)**	**2002 (%)**	**2003 (%)**	**2004 (%)**
Hudson	7.3	9.3	7.2	5.7	8.1	8.0	5.9
Hunterdon	2.7	3.2	2.1	1.7	3.6	3.9	3.2
Mercer	4.4	5.4	4.0	3.0	5.1	4.8	4.2
Middlesex	4.5	5.5	3.8	3.1	5.4	5.4	4.5
Monmouth	4.1	5.4	4.0	3.2	5.3	5.3	4.4
Morris	3.2	4.3	2.8	2.3	4.4	4.4	3.5
Ocean	5.1	6.2	4.6	3.9	5.4	5.7	4.9
Passaic	6.4	8.6	6.2	5.0	7.5	7.7	5.9
Salem	5.3	6.5	4.7	4.4	6.4	6.9	5.5
Somerset	2.9	3.8	2.5	2.1	4.4	4.3	3.7
Sussex	4.2	5.7	3.5	2.9	5.1	5.5	4.1
Union	5.4	6.5	4.8	4.0	6.4	6.3	5.1
Warren	4.3	5.7	4.2	3.1	5.3	5.7	4.3
All	*5.1*	*4.6*	*4.6*	*3.8*	*5.8*	*5.9*	*4.8*

The average annual wage in New Jersey (2000) was $43,691; in 2002 it was $45,182. Disposable personal income rankings showed New Jersey higher than all states except Connecticut and Massachusetts. New Jersey's median household income in 2000 ($51,739) was third highest in the country as reported by the Census Bureau.

The 2003 average New Jersey per capita personal income $40,427) was slightly higher than 2000 as reported by the Census Bureau ($38,372). New Jersey maintained second place in 2000-2003, and has been in the top ten states since 1983.The Bureau of Economic Analysis at the US Department of Commerce showed variation among counties:

New Jersey Per Capita Personal Income ($) by County for Selected Years[#]						
COUNTY	**1996**	**1997**	**1999**	**2000**	**2001**	**2003**
Atlantic	29,415	30,187	32,086	31,618	31,550	31,749
Bergen	40,676	43,123	48,017	50,435	51,900	51,758
Burlington	26,669	27,849	30,747	33,910	34,683	37,105
Camden	25,518	26,500	28,035	29,312	30,496	32,449
Cape May	25,759	26,419	29,455	30,611	31,412	34,386,
Cumberland	20,662	21,663	22,894	22,675	23,616	26,012
Essex	31,411	32,581	34,824	35,919	37,134	37,963
Gloucester	23,374	24,340	27,077	28,296	29,243	31,056
Hudson	24,233	24,943	27,662	28,100	28,584	30,447
Hunterdon	37,675	39,830	44,833	52,107	53,815	55,196
Mercer	33,893	36,598	39,626	40,911	42,317	41,499
Middlesex	29,544	30,881	34,267	36,196	36,691	38,096,
Monmouth	32,401	33,952	37,267	40,639	42,028	43,427
Morris	41,018	42,913	49,957	56,047	58,151	55,796
Ocean	25,113	25,725	27,694	29,694	30,023	31,782
Passaic	24,426	25,560	27,559	29,023	29,355	32,003
Salem	24,374	25,162	27,178	28,949	29,149	29,568

[#] Source: NJ Dept of Labor and Workforce Development Web site; www.wnjpin.net/OneStopCareerCenter/LaborMarketInformation

New Jersey Per Capita Personal Income ($) by County for Selected Years[#]						
COUNTY	**1996**	**1997**	**1999**	**2000**	**2001**	**2003**
Somerset	44,089	46,392	52,078	56,613	55,580	55,443
Sussex	27,134	28,162	30,270	34,563	34,628	38,196
Union	33,090	35,157	38,487	40,016	41,149	40,181
Warren	25,466	26,687	29,079	31,026	31,323	33,579
US	*24,164*	*25,288*	*35,612*	*29,847*	*29,770*	*31,632*

The 2000-2002 average of the New Jersey population estimated to be below the poverty level was 7.8% while the national rate was 11.7%; two states had lower rates than New Jersey. In 1980, 9.0% of New Jersey's population was reported to be below the poverty level; the national rate was 13.0%.

Average retired workers monthly benefit dollars in New Jersey were the highest of any state in 2002 at $989/mo. followed by Michigan ($964). The average weekly unemployment benefit in New Jersey was second highest of all states at $331, exceeded by Massachusetts ($360)

The state continues to have one of the highest AIDS caseloads[*] following New York, California, Florida, Pennsylvania, Maryland and Texas. The HIV/AIDS cases reported below consist of newly diagnosed cases within the state for the current reporting period of 2004. The cumulative total cases of HIV/AIDS is reported for comparison in the second column.

NJ Adult/Adolescent HIV/AIDS Cases Reported January 2004-December 2004 and Cumulative Totals as of December 31, 2004

Age Group (at diagnosis)	Newly Diagnosed 2004		Cumulative Total	
	No.	%	No.	%
13-19	67	2	785	1
20-29	462	17	12,364	19
30-39	865	32	28,419	44
40-49	843	31	16,240	25
49+	447	17	6,359	10
Total	2,684	100	64,167	100

The 2003 tuberculosis rate in New Jersey was 5.7/100,000 population. This rate placed New Jersey eleventh among all states. In 2002 the Centers for Disease Control[⊗] reported the lowest national tuberculosis rate (5.2) in the United States since reporting began in 1953. New Jersey's case rate in 2002 was 6.2 (530 cases). Five other states had higher case rates than New Jersey: Hawaii (11.5), California (9.0), New York (7.5), Texas (7.1), and Florida (6.5). New Jersey's case rate in 1998 (640 cases) and 1999 (571 cases) was 7.9 and 7.0, respectively; nationally, the rates were 6.8 and 6.4.

Currently, two sub-population groups account for approximately 75% of tuberculosis cases: foreign-born persons and US-born non-Hispanic black population. The most frequent birth countries are Mexico, Philippines, Vietnam, India, China, Haiti and South Korea.
Although mergers and acquisitions have increased in recent years, in 2001 New Jersey had 81 acute care hospitals compared to 95 in 1990. The number of organizational affiliations has increased so that the institutional count will vary depending on the selection criterion utilized.

[*] Source: *New Jersey HIV/AIDS Report, NJDHSS,* Division of HIV/AIDS Services, December 31, 2004.
[⊗] Source: Trends in Tuberculosis-United States 1998-2003*, MMWR Weekly*, CDC, March 19, 2004.

INCIDENCE OF RENAL DISEASE IN NEW JERSEY

In 2002, all but three states had an adjusted end-stage renal disease incidence rate that exceeded 200 per million population[Δ]. The *2004 Annual Data Report* of the United States Renal Data System (USRDS) listed six states with higher age, race, sex-adjusted incidence rates than New Jersey compared to ten states in 2001. The New Jersey adjusted incidence rate in 2002 was reported to be 344/million. (Annual incidence rates do not have the stability that averages for a three or five-year period would exhibit.)

The USRDS published adjusted annual incidence rates from 1990-2002. Each year New Jersey showed an increase demonstrating a steady trend: 231, 255, 281, 294, 301, 319, 310, 331, 339, 358, 342, and 349. For 2002, the New Jersey 344 incident rate/million declined somewhat but the data are recalculated each year and may change if additional cases are included.

The average age of consumers starting therapy in 2002 was 62.2 compared with the average age in 1999 of 61.4 Nationally, the median age was reported in the *2004 Annual Data Report* of the USRDS to be 65 in 2002.

According to the ESRD Facility Survey in 2004, 3,251 consumers initiated therapy in New Jersey facilities compared to the 2003 count of 3,325. Older people, in particular those over 65 years of age, continued to represent the largest and fastest growing age group of ESRD beneficiaries. Of the total new starts in 2003, 57% were 65 years or older and 46% were 70 years or older. Nineteen percent were 80 years or older. These percentages varied little from the prior year.

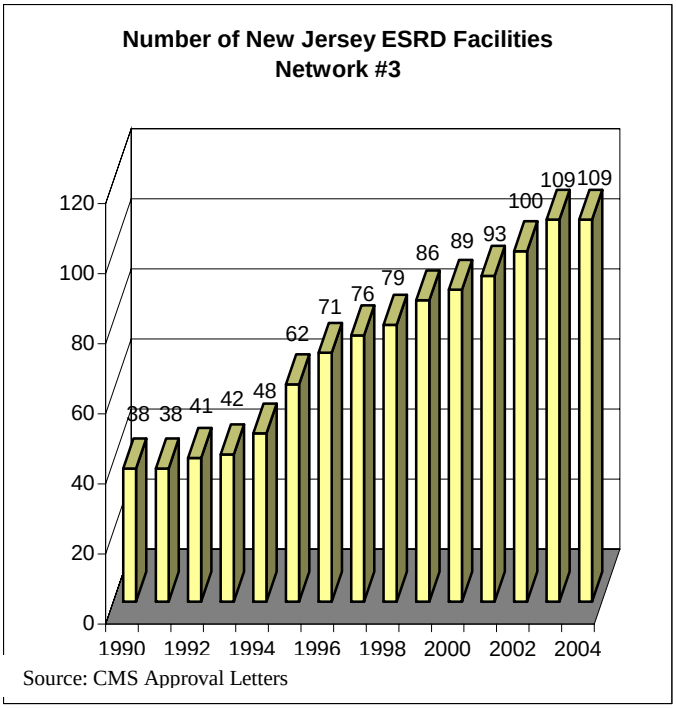
Other characteristics of the New Jersey incident population closely mirror national new case renal statistics: 55% were male and 45% female; 33% black and 60% white.

Among incident cases the most frequently reported primary diagnoses were diabetes (47%) and hypertension (33%). Collectively, these two diagnoses represented the largest proportion of new cases in 2004.

RENAL THERAPY IN NEW JERSEY

The New Jersey Department of Health regulated the approval of all new ESRD providers and expansion of services through the certificate of need process until January 1992. Since that time, chronic ambulatory dialysis is no longer subject to certificate of need requirements. The number of facilities increased from 38 in 1991 to 109 (not including a non-Medicare certified ESRD veterans hospital) in 2004. This is a 287% increase.

In 2004, the total approved station count rose to 2,081. During 2004, the number of Medicare-certified facilities remained constant at 109. Most facilities are no longer hospital-based since 74 free-standing clinics



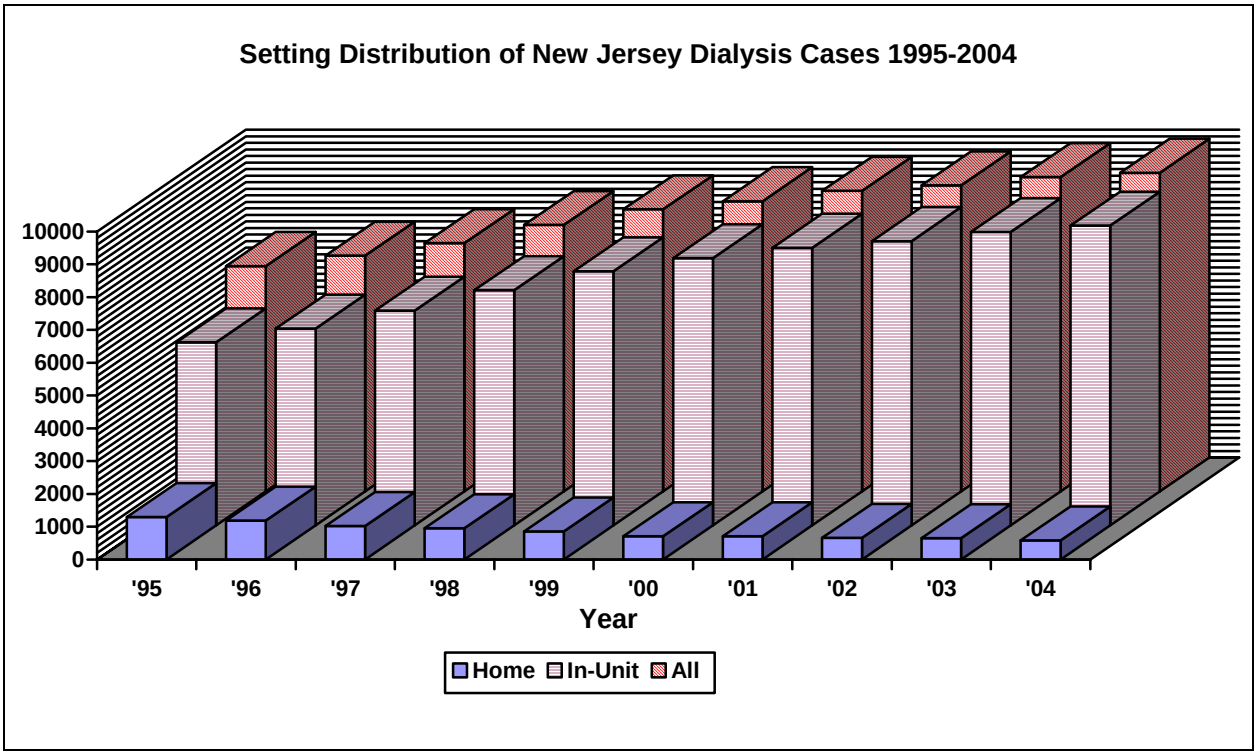
[Δ] Source: US Renal Data System, *USRDS 2004 Annual Data Report: Atlas of End-Stage Renal Disease in the United States.* NIH, NIDDK, Bethesda, Md, 2004.

and 8 hospital satellite facilities provide service. There were 26 hospital-based facilities and one veteran's administration hospital, which is not a participant in the Medicare program.

Almost all facilities were approved to provide staff-assisted hemodialysis except for 2 peritoneal dialysis-only units. Of the facilities offering home dialysis 63% offered CAPD/CCPD training; 17% offered hemodialysis home training. These services reflect the choices among patient and physician preferences for therapy and were available throughout the state.

Staff-assisted hemodialysis, favored by 94% of ESRD consumers (83% in 1996), remained the dominant therapy in the state. Continuous cycling peritoneal dialysis (CCPD) became the dominant home therapy (n=383) with continuous ambulatory peritoneal dialysis (CAPD) the second most prevalent (n=178). Home hemodialysis accounted for only 20 cases statewide in 2004.

The national distribution of modalities reported for 2002 was the following: facility hemodialysis, 65%; home hemodialysis, 0.3%; CAPD/CCPD, 5.7%; other and uncertain, 0.7%; transplant 28.4% (Source: USRDS *2004 Annual Data Report*).



PREVALENCE

The USRDS published adjusted annual point prevalence rates/million population for 1990-2002 by state. New Jersey results were 887, 971, 1041, 1102, 1167, 1221, 1260, 1309, 1361, 1422, 1447, 1477 and 1494 respectively.

The prevalent caseload increased 3.5% over the prior year. Of the approximately 9,631 prevalent consumers receiving dialysis in New Jersey, 56% were male and 44% female. Forty-two percent of the population on dialysis was black, 50% white, with other racial groups constituting the remainder.

Forty-six percent of the consumers receiving chronic dialysis were 70 years or older, and 20% were within the 60-69 age group. Sixty-six percent of the prevalent consumers receiving dialytic therapy in New Jersey during 2004 were aged sixty years or older. The aged population continues to be the fastest growing segment both receiving long-term chronic care and initiating treatment.

Diabetes was the most frequently reported primary disease of all prevalent consumers on dialysis at 42%. Hypertension followed at 32% of the caseload and "other" ranked third at 13%. The majority of consumers (74%) in treatment were diagnosed with either diabetic nephropathy or hypertensive disease--the two leading national risk factors for ESRD.

MORTALITY DATA

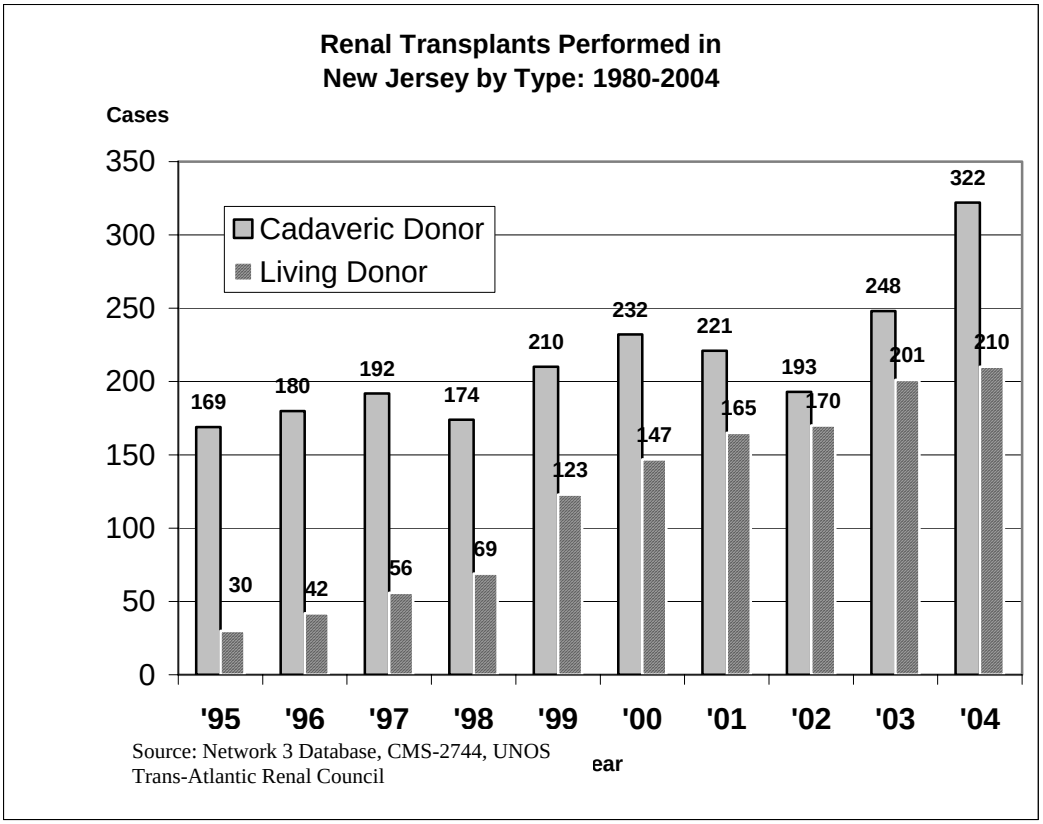
Death notification reports for New Jersey ESRD consumers were analyzed by sex, race, and cause of death. The primary cause of death reported in 2004 continued to be cardiac (46%) which again reflected national data. Infection was reported in 20% of the 2558 death records received. Of all deaths reported in 2004, 54% were white, 23% black; 56% were male, 44% female. Primary diagnoses among deaths reported were diabetes (50%), hypertension (27%), glomerulonephritis (7%), polycystic disease (1%) and other/unknown.

TRANSPLANTATION

Five renal transplant centers serviced the New Jersey ESRD population with referrals also being made to neighboring New York, Pennsylvania and Maryland. Recent years have seen an inflow for transplantation to New Jersey from neighboring state residents as well. Organ procurement activities were the responsibility of two federally-approved agencies, the New Jersey Organ and Tissue Sharing Network (The Sharing Network) and the Gift of Life Donor Program.

In 2004, 444 transplants were performed in New Jersey at federally-certified ESRD renal transplant centers, an increase of 18% over 2003 performance. Of the 444 transplant procedures performed within New Jersey, 261 had cadaveric donors and 185 had living donors. Two patients were transplanted at a non-federally certified transplant facility in New Jersey.

The number of consumers on a waiting list in New Jersey continued to increase to a total of 2,636, 27% higher than the previous year; the extent to which the counts contain duplicate counts is not known since consumers can be listed in more than one donor pool. Unless the donor pool is enlarged, transplantation will not be available to the majority of consumers on the list except, perhaps, after a lengthy waiting period. Alternatively, living donor transplantation may be able to provide some candidates with more timely access to this modality.


Renal Transplants Performed in
New Jersey by Type: 1980-2004
Cases
350
300
250
200
150
100
50
0
Cadaveric Donor
Living Donor
169
30
180
42
192
56
174
69
210
123
232
147
221
165
193
170
248
201
322
210
'95
'96
'97
'98
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Source: Network 3 Database, CMS-2744, UNOS
Trans-Atlantic Renal Council
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Puerto Rico and the Virgin Islands

Geography and the General Population Characteristics

Puerto Rico

Similar to New Jersey, Puerto Rico is densely populated (1,124/sq. mi.) with land area covering nearly 3,425 square miles and a population of 3.879 million (est.)◂. There were 1,027.9 inhabitants per square mile according to the 2000 census. Between 1990 and 2000, the population increased 8%.

Droughts are one of the naturally occurring hazards to the local population. Sediment buildup (60% storage reduction over the last 50 years) in reservoirs reduced the holding capacity of several major water supplies. Reclamation efforts are underway and should reduce the periodic threat to potable water supplies. The U.S. Geological Survey works with 15 local agencies to operate a real-time hazard alert network concerned with rainfall, stream flow, lake levels and beach erosion from catastrophic events⊥.

In recent years Puerto Rico has experienced major expansion in the construction and tourism sectors. Construction of housing, commercial buildings and infrastructure (super aqueduct, urban train, highways) contributed to economic development. Some manufacturing plants did expand but the effect of favorable tax benefit elimination is uncertain for the future. The economic benefits to businesses provided under Section 936 will be completely phased out in 2005.

The 2003 Census Bureau report showed that the labor force (1.378 million) was distributed predominantly among several major types of work: 2% were engaged in agriculture, 10% in manufacturing, 19% in trade and 20% in government positions. Approximately 14% were unemployed in 1998, 13.7% in 1999, 11% in 2000 and 12% in 2003. The closing of the navy's air base at Roosevelt Roads on the eastern shore of the island had a significant effect on local economy. Future use plans are not finalized.

One in every four Hispanic families lives at the federal poverty level with average earnings well below the U.S. national average. Forty percent of all households rely on some form of public assistance. The average monthly benefit paid to retired workers is $527. The average annual employee compensation reported by the most recent Bureau of the Census publication (2000) was $20,064; the average family income was $33,559.

In 1999 there were 525,000 Medicare enrollees and 562,000 in 2002. Medicaid had 1,055,000 enrollees in 1998; more recent data are not available. The local Health Reform Program covers 1.8 million indigent residents.

The birth rate reported by the U.S. Bureau of the Census in 2000 was 15.2/1,000 population and 13.7 in 2002. The death rate (2000) was 7.2/1,000 population and remained stable in 2002. The median age rose from 32.1 in 2000 to 33.8 in 2004 as reported by the Census Bureau. Of the residents, 509,856 (23%) were high school graduates; 418,253 (19%) had a bachelor's degree or higher.

Trend analysis of the 2000 census data suggests that, even though the population is younger than stateside, it is aging at a more rapid pace and the proportion over the age of 65 rose more than that stateside, where it declined slightly. Also of note is the drop in fertility rates which was 2.3 in 1990 but 1.8 in 2000.⊦

◂ Source: *Statistical Abstract of the United States: 2004-2005,* US Census Bureau, US Dept of Commerce, 2005

⊥ Source: GSA Center, US Geological Center, *Island hydrology: Puerto Rico and the US Virgin Islands,* at http://pr.water.usgs.gov/public/webb/webb010

⊦ Source: *The Mainstream Effect-census of Puerto Rico's population,* Alison Stein Wellner, www.findarticles.com/p/articles/mi_m0GDE/is_18_21/ai_80088606

Puerto Rico Population by Age, 2000, 2004 (est.)

Age Group	2000	2004 est.
0-24	1,520,995	1,460,917
25-54	1,513,031	1,554,930
55-64	349,447	402,810
65-74	240,951	269,021
75-84	184,186	207177
All	3,808,610	3,894,855

Source: Table 2 Annual Estimates of the Population by Sex and Age for Puerto Rico: April 1, 2000 to July 1, 2004, Population Division, US Census Bureau, March 2005.

Social security beneficiaries in 2003 (Census Bureau) numbered 688,000 with an average monthly benefit payment of $611 for retired workers, $738 for disabled and $544 for widows/widowers. These payments are lower than in all other areas except American Samoa and the Northern Mariana Islands.

Population characteristics describe basic life choices, such as early acquisition of medical care and the existence of discretionary income to provide adequate housing and nutritional support. Many communities are isolated and lack treated water supplies. The Environmental Protection Agency (EPA) has been working with the local health department's environmental division to provide special water filters, chlorine if needed, and basic education on suitable potable water for drinking.

The 2001 death rates for major causes of death in Puerto Rico are in order: heart disease; cancer, diabetes, cerebrovascular, accidents, chronic respiratory, assault, HIV, motor vehicle accidents as reported by the Census Bureau. The death rate for HIV (18.6) was second (in ranking) only to Washington, DC. Similarly, the rate for diabetes mellitus (64.5) was the highest among all states and the District of Columbia.

The U.S. Virgin Islands

The territory of the Virgin Islands consists of 3 islands - St. Thomas, St. Croix and St. John - and about 50 islets, most of which are uninhabited. These islands are located 60 miles southeast of Puerto Rico between the Caribbean Sea and the Atlantic Ocean in the Lesser Antilles chain of the West Indies. It is an unincorporated territory of the United States administered by the Office of Insular Affairs, U.S. Department of the Interior. The governor and lieutenant governor are elected for four-year terms.

The land area covers 134 square miles with an overall population estimated to be 108,000. There were 810 residents/sq. mi. in 2000. Population density fluctuates among the individual islands. St. Thomas has the highest density with 1,579 persons per sq. mi.; St. Croix has 583/sq. mi. and St. John only 118/sq. mi.

Population of the US Virgin Islands: 1990 and 2000

Island	1990	2000	% change
St. Croix	50,139	53,234	6.2
St. Thomas	48,166	51,181	6.3
St. John	3,504	4,197	19.8
All	101,809	108,612	6.7

Source: US Census Bureau, *Statistical Abstract 2004-2005.*

Residents are comprised of people from the West Indies (45% native to Virgin Islands, 29% born elsewhere in West Indies), Puerto Rico (5%), U.S. mainland (13%), and other (8%)[◂]. Racial composition in the Virgin Islands is estimated to be 80% black, 15% white and 5% other. Spanish and Creole are spoken in addition to English.

US Virgin Islands Population by Age Group: 2000, 2004

Age Group	2000	2004
0-24	42,855	40,182
25-54	44,883	43,670
55-64	11,652	13,848
65-74	5,931	7,015
75-79	1,626	1,965
80+	1,690	2,095
All	108,637	108,775

Source: US Bureau of the Census, International Database.

Approximately 37% of the territory's population resides in urban areas, while 63% is located in rural or suburban developing communities. Forty-six percent of the population resides on the island of St. Thomas. Charlotte Amalie remains the urban center of St. Thomas. Christiansted and Frederiksted are the major towns on St. Croix.

There are two international airports in the Virgin Islands; one is on St. Thomas and the other on St. Croix. Transport to St. John is via scheduled ferry from St. Thomas or St. Croix. Cars on the islands use 856 km of paved highways.

The birth rate reported by the U.S. Census Bureau has been declining since 1990 when it was reported to be 21.8, 18.1 in 1995, 12.9 in 2000. The median age was reported to be 33.5 in 2000 and 35.9 in 2004. The death rate was reported to be 4.6 in 1990, 5.8 in 1995 and 5.3 in 2000. The major causes of death in 2001 were in order: heart disease, cancer, cerebrovascular diseases, accidents, diabetes and assault.

In 2000 the Census Bureau reported that of the 65,603 residents 25 years and older, 17,044 (26%) were high school graduates and 10,989 (17%) held a bachelor's degree or higher. The median income was $28,553 in 2000. In 2003, 15,000 beneficiaries received social security benefits: 11,000 retired workers, 2,000 widows/widowers and 2,000 disabled workers. The average monthly benefit for retirees was $804, $860 for disabled and $690 for widows and widowers.

The primary economic engine of the islands is tourism[◂]. It accounts for more than 70% of gross domestic product. Approximately 32% of the employed were in retail sales or the services provided for recreation, motels, hotels and restaurants. Manufacturing includes textile, electronics, pharmaceutics and watch assembly. The estimated unemployment rate in 2003 was 9.3%, higher than the 6.2% in 1994. The total labor force is estimated to be 48,000 distributed among services (62%), industry (20%), agriculture (1%), and other (17%).

In 1989 hurricane Hugo caused $500 million damage, followed in 1995 by hurricane Marilyn from which residents have not yet completely recovered and which extended to the tourism industry[×]. Local business owners continue to lament the drop in available advertising money that is funded through hotel taxes since many hotels had to close because of hurricane damage. In 1997 it was anticipated that only $8.5 million would be raised through the hotel tax which was considered to be insufficient. The inventory of

[◂] Source: www.infoplease.com/ipa/A0113951; www.cia.gov/cia/publications/factbook/print/vq
[◂] Source: www.infoplease.com/ipa/A0113951
[×] Source: www.lonelyplanet.com/destinations/caribbean/us_virgin_islands

hotel rooms before the hurricane was estimated to be 1,400 while in 1997 was approximately 850. Governmental fiscal administration was hampered by an imbalance in funds received compared to funds to be disbursed to vendors, tax refunds, and overdue wages. However, cruise ships returned after the dock was reconstructed; in 2003 passengers numbered 1.7 million.[×]

One of the world's largest petroleum refineries is on St. Croix. Little agriculture is present and most foodstuffs are imported.

The Virgin Islands have a strategic importance located along the Anegada Passage, which is a key shipping lane for the Panama Canal. Saint Thomas has one of the best natural deepwater harbors in the Caribbean.

The Islands have unique waste disposal problems. The U.S. Army Corps of Engineers conducted an environmental assessment at a St. Thomas landfill in 1996 and found that mercury vapors and phosphogenes were present which, after long-term exposure, can produce illness and certain forms of cancer. Alternative solutions are being explored.[√]

(Puerto Rico and the Virgin Islands are not included in all tables of the various demographic reports utilized to describe these areas, which limits some comparisons to national published data.)

Renal Disease: Puerto Rico and the U.S. Virgin Islands

The number of newly diagnosed ESRD cases, inclusive of those who started treatment in out-of-area facilities, was 1,314, a 10% increase from 2003. Sixty-two percent of the newly diagnosed were reported to have a primary diagnosis of diabetic nephropathy. This continued to parallel the national trend of the growing number of diabetics starting dialytic therapy and represents a marked increase from 1990 when diabetes as the primary cause in new cases was only 45%. Hypertension was the second highest reported diagnosis at 15% and 9% of the newly diagnosed caseload was reported with a diagnosis of glomerulonephritis.

These rates vary when analyzing the data received on all prevalent consumers alive at year-end 2004 on the islands. At year-end 3,669 consumers received treatment, a 3% increase from 2003. Of these consumers, 55% reported diabetes as primary cause of renal failure, 14% glomerulonephritis and 17% hypertensive disease. The majority of consumers were reported as racially mixed (66%) and male (62%).

Age grouping is similar for both new cases and the prevalent dialysis patient population on the islands. In the incident and prevalent population, consumers in the 50-69 age group are dominant; 52% and 54% respectively. Thirty-one percent of prevalent cases are between the ages of 30 and 54. Twenty-eight percent of the incident cases are age 70 or more. Twenty-two percent of the prevalent cases are age seventy or older.

The primary cause of death for ESRD consumers treated in Puerto Rico and the Virgin Islands at year-end was cardiac (36%); infection ranked second (34%).

Treatment Modalities

Thirty-seven facilities were approved on the island of Puerto Rico to provide dialysis services, one transplant center and three dialysis facilities within the U.S. Virgin Islands (one hospital-based unit on the island of St. Thomas, one hospital-based unit on St. Croix and one free-standing facility on St. Croix). Twenty-eight facilities on Puerto Rico are freestanding clinics. There is one veteran's administration

[×] Source: www.lonelyplanet.com/destinations/caribbean/us_virgin_islands

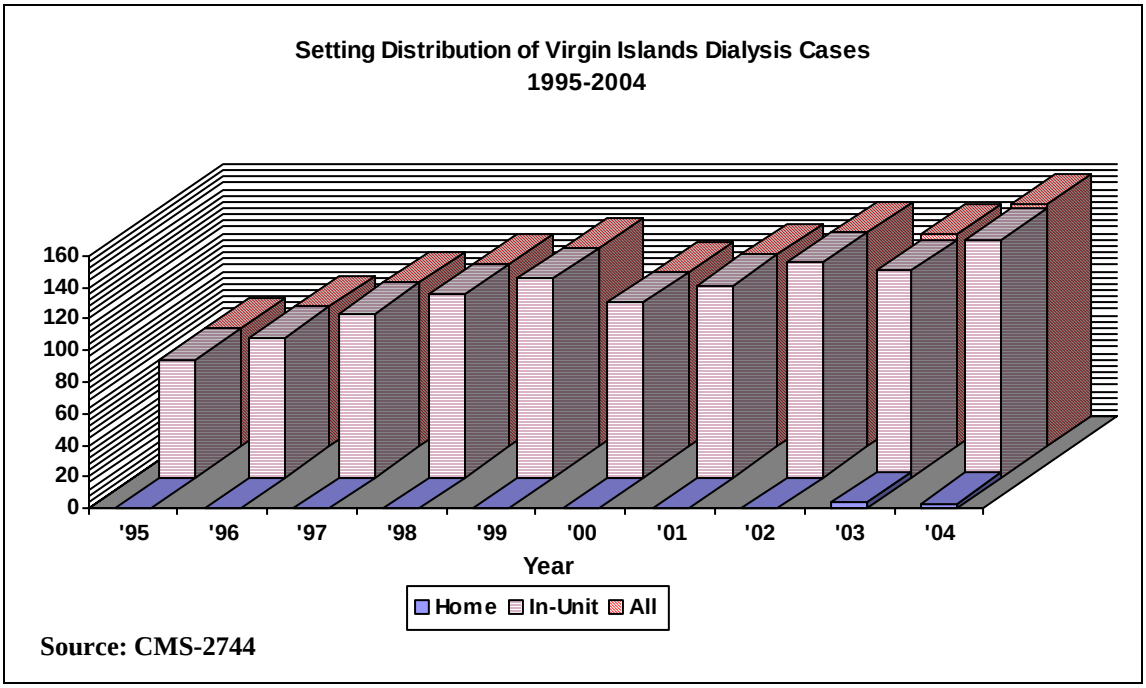
[√] Source: USEPA, Office of International Activities, *A Report on the State of the Islands,* at www.islands.vi/~arnoldvb/chapter5

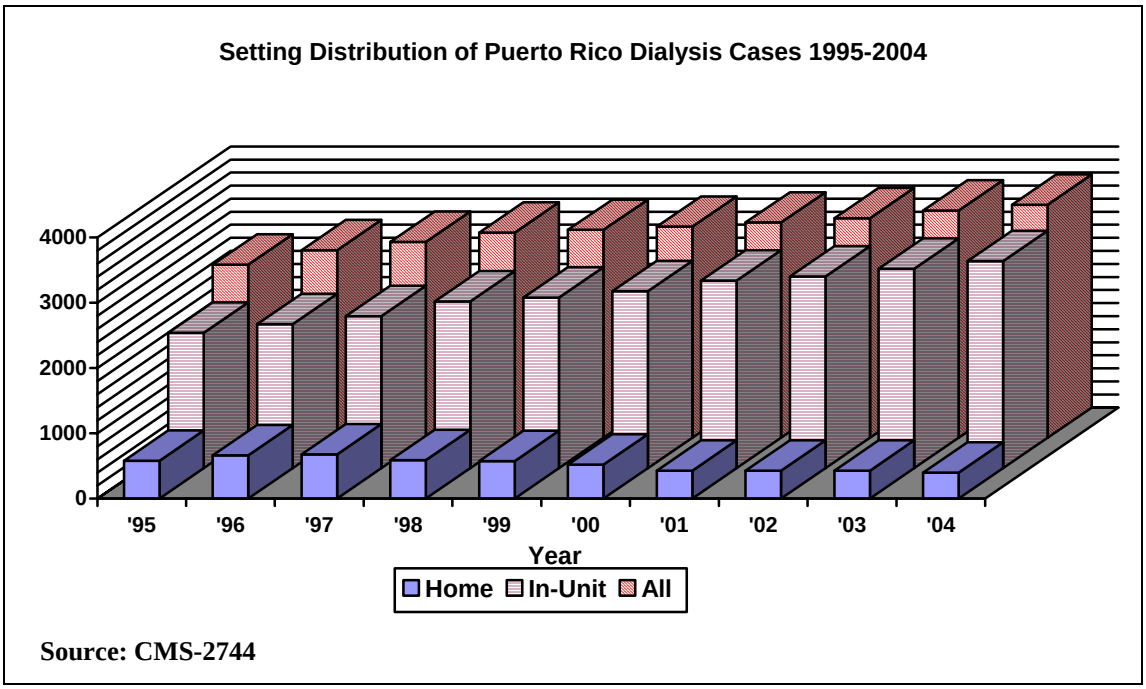
hospital and 8 hospital-based units on Puerto Rico. The station count increased to 790 from 776 in 2003 (inclusive of Puerto Rico and the Virgin Islands). The three facilities on the Virgin Islands had a total of 30 stations and a total of 152 cases at year-end.

Treatment choice continued to favor staff-assisted hemodialysis—3,173 (89%) consumers in Puerto Rico and all consumers on St. Thomas and St. Croix. Self-care training in CAPD, CCPD and home hemodialysis were provided in Puerto Rico in spite of limited housing conditions. Eighty-five percent of the home population was on home CCPD. In 2004, 341 consumers were on CCPD and 55 consumers were on CAPD. Four consumers used home hemodialysis. The combined total of consumers on various forms of home dialysis in Puerto Rico equaled 400 in 2004, 427 in 2003, 426 in 2002, 521 in 2000, 574 in 1999 and 679 in 1998. In St. Croix, three consumers were on CAPD.

Eighty-six transplants were performed in 2004 at the one Medicare-approved transplant center. This was an increase of 24% above 2003 performance. Of these procedures, 61 were from cadaveric donors. There were 428 consumers on an active waiting list.

Formerly, the organ procurement agency was located at the transplant hospital and was part of that organization. In 1996 a separate agency was established, Life Link of Puerto Rico, which is affiliated with Life Link of Florida.





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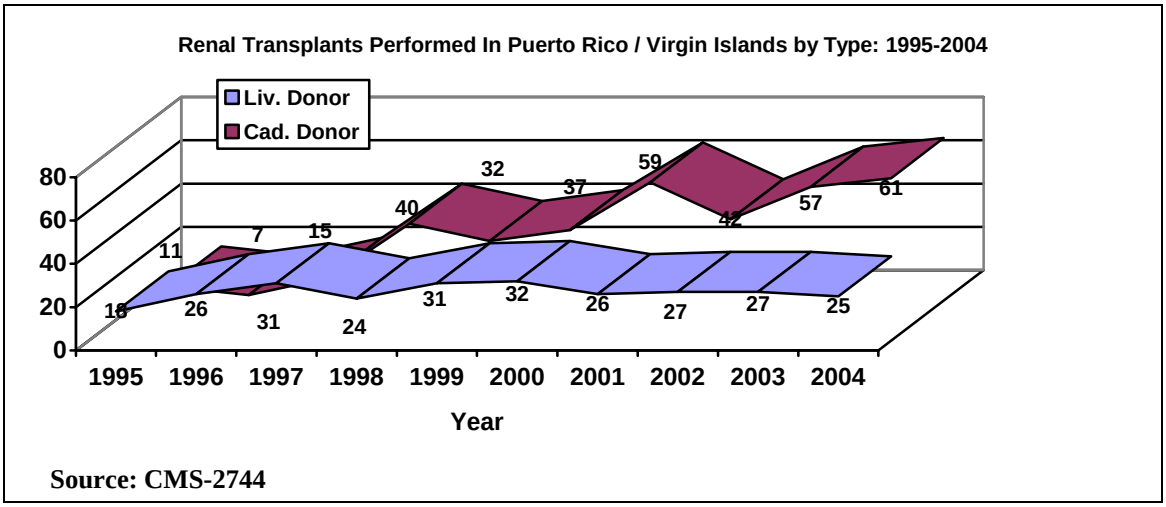


Source: CMS-2744

(Note: USRDS data do not provide Puerto Rico/US Virgin Island-specific comparative data.)

B. Network Structure

1) Staffing

Professional and clerical staff conducted daily activities of the network organization under the direction of the Board of Trustees and in accordance with federal guidance.

2) Names And Titles Of Staff

Cheryl Brown *Data Clerk*	Hazel Dennison *QI Administrator*	Tricia Phulchand *Office Manager*
June Chronic Huhn *QI Coordinator*	Chris Brown *Data Manager*	Michele Inglese *Sr QI Coordinator*
Patricia Dorsa *Bookkeeper*	Joan Solanchick *Executive Director*	

3) Key Responsibilities

The project director was Joan Solanchick, who administered the contract, maintained external relations through ongoing communication with other agencies, state programs and the general public, and supervised daily operations.

Hazel Dennison, MSN, RN, CNN, APN, C is Quality Improvement Administrator with over twenty years experience in ESRD patient care. She monitors all quality improvement efforts, plans future project implementation and works with individual facilities.

Michele Inglese, RN, and June Chronic Huhn, RN, MPA, CNN are Quality Improvement Coordinators, and in these positions they assisted with the conduct of improvement activities, monitored facilities, performed on-site visits, did clinical data review and responded to consumer problems.

Chris Brown developed data analysis and statistical reports. He assured computer support operations, validation, testing and design of special programs that implemented federal directives. Additionally, he trained facilities in the use of new federal VISION software use and implementation.

Accurate data analysis is based on careful processing, manual review and data entry. Cheryl Brown performed data entry, resolved discrepant reporting, monitored the accuracy and completeness of the database.

Tricia Phulchand monitored all project submissions as well as assisted in the implementation of facility transmission of VISION data, monitored complete and timely data submission.

These individuals provided the clinical and administrative expertise to assure reliability of statistical data and oversight of quality improvement activities.

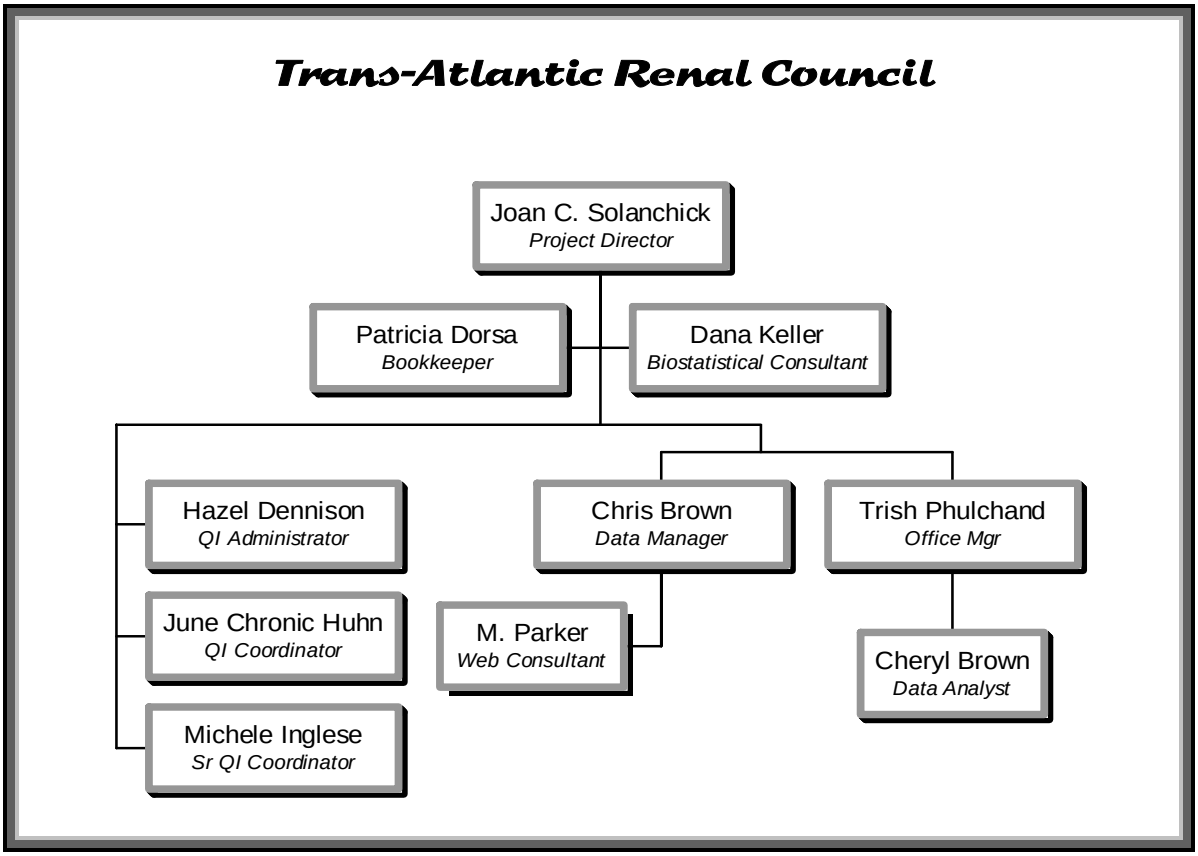
OPERATIONS

There are two major functions within the operation of the network: quality improvement and data management. It could be maintained that quality improvement is the sole function of the network and data analysis serves only to focus and measure the quality improvement function.

Quality improvement personnel were responsible for staffing the Medical Review Board and all related activities, the federal clinical performance measures project, local quality improvement activities and educational programming. Staff prepared draft material for review by the Medical Review Board, monitored developments in the field, reviewed reports submitted by each facility and analyzed comparative results. Facility site visits were conducted when appropriate and regional training sessions conducted.

Data management personnel were responsible for all data input, report production, generation of diskettes and transmission of data to CMS. They subjected data to tests of statistical significance and interpreted results for clinical personnel as well as assisted in designing studies and producing reports.

Clerical personnel prepared documents, correspondence and general mailings as well as maintained files in a manner consistent with usual office practice.



Network staff conducted the ongoing collection and processing of data, review of compliance with federal requirements as well as network goals and objectives, and distribution of pertinent information to all ESRD facilities within the defined geographic region.

The Council of member facilities provided the direction for monitoring performance outcomes and measuring the quality and appropriateness of care. The Medical Review Board and the Board of Trustees provided invaluable advice and expertise to achieve improvements in patient care. In addition, a resource pool of knowledgeable ESRD consumers and other highly skilled clinical nephrology

professionals (physicians, registered nurses, social workers and dietitians) was developed to act in a consulting role for periodic review of educational materials, special studies, core indicators and speakers at educational meetings.
This resource pool has been valuable in assisting staff to test new data requirements and changes in quality improvement activities, and to analyze the impact of advancing technology or areas of interest. All board and committee members serve voluntarily with no compensation.

4) Committees

The basic committee structure includes the Board of Trustees and the Medical Review Board. Other committees and subcommittees are established when the need arises. Currently, the Data Systems Implementation Committee is providing direction and oversight for Web site contents.

5) Functional Description

Network Council

The Council provided broad direction and guidance in the development of goals for self-care, transplant referrals and criteria selection for monitoring performance of providers and plans for improvement.

Representation on the Council was multidisciplinary, culled from professionals with demonstrated expertise in their specific field and representative of the geographic characteristics of the network.

The Trans-Atlantic Renal Council ('Council') was composed of thirty-three (33) regular members: twenty-four (24) from New Jersey, six (6) from Puerto Rico/Virgin Islands, and three (3) consumers. The formal Council representatives reflect the geographic area encompassed by the network as well as the various disciplines and types of facilities contained within the network stipulated by federal regulations. All Council members were selected from volunteers and approved by the Board of Trustees. Liaison members from governmental and voluntary agencies affiliated with the care of ESRD consumers were invited. To the extent possible, Council membership was restricted to not more than one person from a facility or affiliated group of facilities. Council meetings are open and a significant number of the renal community attends the annual meeting.

The geographic representation by discipline is illustrated below:

North NJ	Central NJ	South NJ	Puerto Rico
1 consumer	1 consumer	1 consumer	
7 physicians	3 physicians	3 physicians	3 physicians
2 registered nurses		1 registered nurse	2 registered nurses
1 social worker		1 social worker	
2 administrator	1 administrator	1 administrator	1 administrator
	1 dietitian	1 dietitian	

Council formal representation by type of facility follows:

	New Jersey	Puerto Rico
Hospital-based	7	2
Non-profit satellite	3	
Corporate provider	13	4
Patients	3	

Current members include:

Alexandre Ackad, MD	Noemi Figueroa, BSN	Robert Motacki
Charles Appel	Melvin Goldblatt, MD	Linda Powell, RD
Kevin Barber, MD	Stuart Homer, MD	Joel Notkin, MD
Mary Buckley, RN	Suzanne Juliano, RN	Robert Rigolosi, MD
Raphael Burgos Calderon, MD	Toros Kapoian, MD	Carlos Rivera Bermudez, MD
Carol Cahill, MS, RN, CNN	Linda Klein	Paula Ruiz, RN
John Capelli, MD	Phyllis Leggett, MSW	Marien Saade, MSN, CNN
William Chenitz, MD	Anita Lipman	Judith Scerbo
Debra DiNuzzo, RD	Mary Lorenzo, MSW	Richard Sherman, MD
Luis Emanuelli, MHA	Neil Lyman, MD	Jorge Weber, MD
Paul Fine, MD	Phyllis Michelli, LCSW	Ronald Zanger, MD

The Council met one time as allowed under contract. This meeting was used to present comparative data on local and national goals and provide educational programming on new technology and areas of interest. The meeting was held on November 17, 2004 at the Sheraton Woodbridge Place in Iselin, New Jersey. Lecture topics and speakers were:

Council Goals and Activities	Jorge Weber, MD *President, Board of Trustees*
Arteriovenous Fistula Creation and Management: Nephrologist's View	Vo D. Nguyen, MD *Medical Director* *Renal Care Group of the Northwest*
Arteriovenous Fistula Creation and Management: Vascular Surgeon's View	William C. Jennings, MD *Associate Professor of Surgery* *University of Oklahoma College of Medicine*
Social Worker's Role in Access Management	Phyllis Micchelli, LCSW, QCSW, BCD *Renal Social Worker* *Newark Beth Israel Medical Center*
AVFistulas: *A Community's Experience*	Carol Cahill, RN, MSN Paul Fine, MD *Morristown Memorial Hospital* Suzanne Juliano, BSN, CNN *Holy Name Hospital* Robert Motacki, MS *Dialysis Clinic, Inc.*

An annual meeting highlight was the presentation by Julie Ahmet, of the *Ahmet B. Ahmet Award* to a consumer elected by the Boards from the many inspirational nominations submitted by facility staff.

Seven posters prepared by New Jersey facilities were displayed at the annual meeting.

BMA-King's Court	*Modality Education-Using Three Prong Approach* Judy Semptimphelter Fran Swire, RN, CNN
DCI North Brunswick	*DCI North Brunswick Implements Fistula First Program* Lisa Bross Gajary, LPN Mary Lou Clancy, RN, CNN

DCI North Brunswick	*Employee Health- Decreasing Employee* Anxiety Through the PEP Procedure with OraQuick Kathy Searson, RN, BS, CNN Lisa Bross Gajary, LPN
Hackensack University Medical Center	*Care-mapping in Dialysis* Sharon Mancini, RN, BSN Maryori Kerschner, RN, APN-C Deirdre Ramos, RN, APN-C
Lillian Booth Dialysis Center	*Phosphorus Survivor* Alice Hayes, BSN, CNN Joanne Lewandowski, MA, CDE, RD
Renal Ventures Bayonne Renal Center	*Bayonne Renal Center-Two Years in Review* Nancy Foley, RN, CNN Rosario Benales, RD Philomena Servodio, MSW Joyce Dizon Gerard Bernales
Robert Wood Johnson University Hospital	*Secondary Hyperparathyroidism* Sarah Tomasello, PharmD, BCPS Garletha Allen, BSN, CNN Robin Roberts, RN, CNN Selena McClinton RNC Alison Trager, MS, RD Colleen Gallery

MEDICAL REVIEW BOARD

The Medical Review Board (MRB) evaluates the appropriateness of ESRD care, treatment procedures, and services delivered to ESRD consumers. The prescribed composition of the MRB is: (12) members and a chairperson from the following categories: a minimum of one physician board-certified in nephrology, an experienced nephrology registered nurse responsible for nursing services, a licensed renal social worker, a registered renal dietitian and a patient representative. All of the members are engaged in ESRD treatment.

The 2004 Medical Review Board was composed of one consumer, one registered dietitian, one social worker, one administrator, three registered nurses and five physicians. Three members were from Puerto Rico and the remainder were from New Jersey. The following chart illustrates the MRB's composition:

Type of Facility	North NJ	Central NJ	South NJ	Puerto Rico
Hospital-based	3 physicians		1 dietitian	
Non-profit satellite		1 administrator		
Corporate provider	1 physician 1 social worker 1 nurse		1 physician	1 physician 2 nurses
Patient		1 patient		

The Board of Trustees accepted nominees for election to the Medical Review Board from the active organizational members. An individual must possess the qualifications and have demonstrated their

ability to evaluate the quality and appropriateness of care delivered to ESRD to serve on the Medical Review Board.

The MRB has the responsibility for the development of criteria and standards for evaluation of care; review of facility protocols for patient modality selection; review of patient grievances as necessary according to standard procedures adopted by the Board; development of protocols for individual case review; evaluation of existing available services and recommendations for the addition of alternative services as needed; the analysis of facilities' compliance with network goals and recommendations for improvement.

No person serving on the MRB may have responsibility for review of any case in which he/she has, or had, any professional involvement, received reimbursement or supplied goods. No person serving on the MRB with a financial interest, direct or indirect, in a facility furnishing ESRD services may review the ESRD services of that facility. Confidentiality assurances are utilized by the MRB to protect the rights of consumers, providers, and facilities.

The activities of 2004 included reviewing facility-specific data for, reports of the Clinical Performance Measures project, the National Vascular Access Improvement Initiative, and other data from CMS. There were no patient grievances to review.

The MRB meeting dates and locations were:

March 3, 2004	Forsgate (Jamesburg, NJ)
June 2, 2004	telephone conference call
September 1, 2004	Forsgate (Jamesburg, NJ)
December 1, 2004	telephone conference call

BOARD OF TRUSTEES

The Board of Trustees ('Board') consisted of eleven (11) members. Upon resignation of a member, inability to complete a term of office, or non-attendance at two (2) consecutive board meetings, the position would be deemed vacant and would be filled by a new member selected by the president of the board. The new member then would serve for the unexpired term held by the member whose position he/she filled.

The board elected from among its membership the following officers: president, vice president, secretary, and treasurer. The president served as the president of the board and chairman of the Council, and monitored all network operations with the project director. The vice president presided or acted in the absence of the president. The secretary was responsible for keeping minutes of all board meetings and assured proper maintenance of all records and reports (except financial) for the Council. The treasurer was responsible for reporting the financial status and budget preparation of the Council.

The 2004 Board of Trustees was composed of one consumer, one dietitian, one social worker, one administrator, two nurses and five physicians. One board member was from Puerto Rico and the remainder were from New Jersey. The chart below illustrates the Board's composition:

Type of Facility	North NJ	Central NJ	South NJ	Puerto Rico
Hospital-based	2 nurses 1 social worker	1 physician	1 physician	
Non-profit satellite	1 physician			
Corporate provider	1 admin	1 physician	1 dietitian	1 physician
Patient			1 patient	

The election of officers took place at a regularly scheduled meeting of the Board. Election of officers was by simple majority of those members present and voting.

The board monitored and directed the daily operation of the network organization.

The board has the authority to:

- Employ and terminate any personnel required for the business of the network;
- Prepare a plan which defines network goals, objectives and implementation of objectives;
- Prepare an evaluation methodology to measure progress;
- Develop network operating and governing policies and procedures;
- Suggest alternative approaches to meeting goals and objectives for the network's consideration;
- Review and update the network plan on a regular basis;
- Review all fiscal matters of the network and review records on such matters which include, but are not limited to, the collection and disbursement of all funds;
- Certify the representatives for appointment to the Council, and keep up-to-date records of the membership of the Council;
- Appoint members and designated alternates to the Medical Review Board
- Review the By-Laws, amending them when necessary.

To further assure a broad perspective on appropriateness of care and outcome measurements, a transplant surgeon and board certified pediatric nephrologist may serve on the board or as a consultant to the board. These members are selected based on their expertise to further promote the goals and objectives of the network.

The Board of Trustees meeting dates and locations were

March 17, 2004 - Forsgate (Jamesburg, NJ)
June 16, 2004 - telephone conference call
September 8, 2004 - Forsgate (Jamesburg, NJ)
December 15, 2004 - telephone conference call

DATA SYSTEM IMPLEMENTATION COMMITTEE

This committee was formed in order to discharge the network's responsibility to assist facilities to provide efficient care by utilizing current technology. The TARC Web site was developed and maintained to educate consumers and the public, dialysis professionals, and translated into Spanish for the Hispanic communities of New Jersey and Puerto Rico.

The Data Implementation Committee is comprised of a dietitian, a dialysis technician, nurses, an information technology coordinator and a social worker who helped to plan, organize, develop and evaluate the necessary components of the Web site’s professional section. The format was further developed and expanded to include, but is not limited to, the following categories: NVAII and *Fistula First* information, end of life palliative care, disaster management, disaster planning, infection control and patient safety. The professional Web site was officially on line in May 2004. TARCWeb trends were reviewed for the number of visitors and Web pages visited on the consumer and professional Web site.

In 2004, the Data Committee recommendations for the development of the professional Web site content were reviewed and Web links added as recommended and approved. Links and resources were researched for additions or deletions, educational and palliative care links and resources were added to the consumer section. The nephrology team section was restructured.

During 2004, the English and Spanish consumer Web sites were periodically reassessed, revised, and maintained. The dialysis facility locations and services were reviewed, revised and updated as new

facilities were approved or facilities were purchased by other dialysis corporations. The Web links were reviewed and revised as needed for both the English and Spanish Web sites.

The question and answer portion of the site allowed visitors to post ESRD-related questions. A wide variety of questions in both English and Spanish were answered by Medical Review Board members. The breadth of questions included many topics including but not limited to the following: the causes and symptoms of kidney failure, kidney diseases, blood pressure, kidney transplantation and donation.

The Data System Implementation Committee was composed of three nurses, one social worker, one dietitian, and two technicians. The chart below illustrates the committee's composition:

Type of Facility	**North NJ**	**Central NJ**	**South NJ**
Hospital-based	1 nurse 1 technician		
Non-profit satellite		1 technician 1 dietitian	
Corporate provider	2 nurses		1 social worker